The Division of Mental Health and Addiction

CHAPTER 1

Introduction

The Indiana Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) is pleased to report on its services, progress, and future plans in this, its fourth biennial report. A notable change during the 2000-2001 biennium was the division's name change—from Division of Mental Health to Division of Mental Health and Addiction (HEA 1813).

The 2000-2001 biennium (July 1, 1999, to June 30, 2001) brought positive change to the field of mental health and addiction treatment. The biennium saw a growing awareness of mental health issues and a reduction in the stigma associated with receiving treatment for mental illness. This heightened awareness was marked by the publication, in 1999, of the first U.S. Surgeon General's report issued on the topic of mental health. This report conveyed two important messages; first, that "mental health is fundamental to health" and second, that "mental disorders are real health conditions." A positive theme expressed in the Surgeon General's report is that many effective treatments exist for mental illness and that the availability and effectiveness of new treatment options continues to grow.

In Indiana, there are continued efforts to shift consumers from state psychiatric hospitals into community based care. Advances in psychosocial and rehabilitation approaches, the development of new generation medications, and case management services allow more consumers to be effectively treated in the community.

The services provided by the state are guided by the provisions of Public Law (P.L.) 40. Passed in 1994, this law established service reform that focuses on a continuum of care designed to provide the citizens of Indiana with the highest quality of services available at the most affordable cost. P.L. 40 also requires the DMHA to submit a biennial report to the Governor and legislative council.

The 2000-2001 DMHA Biennial Report is quite different from the first report published in 1995. The format has changed to reflect the growing demand for web based information. Detailed information previously contained in this report is under development and will be placed on the Indiana FSSA website, *http://www.in.gov/fssa/servicemental/*.

The Indiana Family and Social Services Administration

The Indiana Family and Social Services Administration (FSSA) was formed in 1992 from existing state social service agencies. As one large agency the FSSA is able to better address the needs of families and individuals by developing comprehensive social service systems. The FSSA operates on the mission of "people helping people help themselves." The DMHA is one division under the FSSA.

Indiana Division of Mental Health and Addiction

The mission of the Indiana Division of Mental Health and Addiction is "to ensure that Indiana citizens have access to appropriate mental health and addiction services that promote individual self-sufficiency." Several strategies fuel this mission including a partnership with consumers and families, representation of

the taxpayer through wise stewardship of tax dollars, and setting quality of care standards for the provision of addiction and mental health services.

The functions of the DMHA can be divided into two main areas – state psychiatric hospital-based services and community services. The DMHA operates six state psychiatric hospitals and is responsible for all functions and services performed therein. In the community, the DMHA serves as a general contractor, overseeing the services delivered by subcontracted community providers.

The DMHA serves the public through five offices. The Office of Public Policy, serving as the planning and policy development arm of the DMHA, operates a centralized data repository, prepares official reporting documents, coordinates legislative efforts, and monitors federal initiatives and grant compliance. This office operates six bureaus that focus on the needs of specific populations of people (see Appendix 2).

The Office of Transitional Services is responsible for the expansion of community-based services for persons with mental illness and addictive disorders. This office allocates funds for treatment, research, and substance abuse prevention projects, provides technical assistance to community providers of services, works to maximize and expand provider revenue sources, and publishes a "report card" that evaluates providers on accessibility, acceptability, impact, and value.

The Office of Contract Management certifies or licenses community mental health centers, managed care providers, all addiction treatment providers in Indiana, and freestanding psychiatric facilities. In addition, this office prepares and monitors contracts, oversees adherence to quality assurance standards, and establishes contractor data reporting requirements.

The Office of Client Services oversees the state psychiatric hospitals and is presently refining services to better meet the needs of persons who benefit from this intensive level of care and treatment.

The Office of Support Resources manages internal resources and also functions as the liaison to Family and Social Services Administration (FSSA) Administrative Services (Human Resources, Budget, Accounting, Organizational Development, and Procurement).

DMHA PUBLIC INVOLVEMENT

A primary tenet of Indiana Mental Health Reform P.L. 40 is the active involvement of consumers, family members, advocates, and persons with professional expertise at all levels of the system. This involvement often takes the form of an advisory committee. Committees have been formed for each of the "special populations" bureaus in the DMHA and can be convened to work with any project or issue being addressed. Committee members are frequently involved in the development, implementation, and evaluation of policies or services.

In addition, public involvement is encouraged through the newly created DMHA Office of Consumer and Family Affairs (OCFA). Established in April 2001, OCFA assures that the interests of consumers of addiction and mental health services and their families are represented at all levels of DMHA planning and policy development. The DMHA was fortunate to obtain the services of a dedicated prosumer—an individual that is both a professional and a consumer—to head up this initiative. The OCFA developed a sixteen member Consumer Council that meets bi-monthly and is composed entirely of consumers and family members. The chair of the Consumer Council was also appointed to the Division of Mental Health and Addiction Advisory Council to facilitate communication between the two councils and to provide ongoing input on behalf of consumers and family members.

During the first year of operation, the Office of Consumer and Family Affairs worked with consumer and family advocacy organizations to increase their involvement and effectiveness, to identify consumers and family members to serve on DMHA advisory groups and committees, and to conduct focus groups throughout Indiana to determine consumer needs. The Director of OCFA also serves as an active participant on DMHA's Policy Development Committee.

OVERVIEW OF CHANGES AND EVENTS OF THE 2000-2001 BIENNIUM

Several new services and activities were initiated in the past two years. The following text highlights some of the major developments and service changes within the DMHA.

Olmstead Mental Health Grant

The federal Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS) awarded grants to the states as part of the New Freedom Initiative. Those grants have been used by the states to assure that the mental health system is an active participant in state-level planning related to the *Olmstead* Decision of the U.S. Supreme Court. In response to the *Olmstead* Decision, states—in compliance with the Americans with Disabilities Act (ADA)—are developing plans to move individuals who are in institutions into less restrictive community placements. In addition, state plans include the development of necessary services to support and maintain community integration and to provide more alternatives to inpatient care.

The Indiana DMHA dedicated their SAMHSA grant funds ($20,000) to identifying and involving consumers and family members in the Olmstead planning process. Through the Office of Consumer and Family Affairs, the DMHA contracted with Key Consumer Organization, Inc., and the Indiana Chapter of the National Alliance for the Mentally Ill (NAMI) to conduct focus groups of consumers and family members in order to solicit input and to encourage participation in the planning process. Information was shared with interested persons and organizations regarding the FSSA Olmstead Plan including providing notice of public hearings that were held across the state. The DMHA also worked closely with Advocates for Human Potential, Inc. (AHP), the national contractor for the Olmstead Initiative, to obtain and disseminate information on Olmstead and the New Freedom Initiative and to provide input at the national level.

Task Force on Co-occurring Mental Illness and Substance Abuse Disorders

The Task Force on Co-occurring Mental Illness and Substance Abuse Disorders published its Final Report in September 1999. The Task Force was formed at the request of the Mental Health and Addiction Advisory Council to study issues related to services for persons with co-occurring mental illness and substance abuse disorders, a topic identified at both the state and national level as a critical issue. The Task Force adopted as its goal, "One seamless system of services for people with co-occurring mental illness and substance abuse disorders."

The study found that:

- 223,000 Indiana Hoosiers have a co-occurring mental illness and substance abuse disorder,
- a majority of the 160,560 independent-living Hoosiers who have co-occurring disorders are receiving no treatment, and
- the severity of emotional and behavioral problems among adolescents is associated with increased likelihood of substance abuse.

The Task Force developed twelve recommendations in five major categories. A copy of the report may be obtained from the DMHA.

Indiana Grassroots Prevention Coalitions Initiative

In July 1999, the Substance Abuse and Mental Health Services Administration (SAMHSA) awarded $7.5 million to Indiana, under the Secretary of Health and Human Services' Youth Substance Abuse Prevention Initiative State Incentive Grant program. This initiative seeks to encourage alcohol, tobacco, and other drug abuse prevention providers to utilize programs that have scientific evidence of their effectiveness.

Indiana's award, in the form of a cooperative agreement between the Office of the Governor and the SAMHSA Center for Substance Abuse Prevention (CSAP), will be paid over three state fiscal years (2001 to 2003). DMHA was named as the agency to administer the initiative. Indiana's grant has been used to foster statewide coordination for planning and implementing drug abuse prevention strategies that are scientifically-based and have demonstrated evidence of effectiveness. It also provided awards to 16 communities in Indiana to implement new policies, practices, and programs to engage private citizens—parents, youth, and neighbors—in developing solutions to drug problems in their own communities and neighborhoods.

A major outcome of the project will be the development of the Plan to Improve Indiana's Prevention System. Local and state agencies and organizations provide Indiana's prevention infrastructure and services. Strategies to improve the prevention system will enhance their efforts. Among the strategies are increased collaborative training opportunities to develop the prevention workforce, a data warehouse to use in prevention planning, and options to redirect prevention funding to programs and practices that are science-based. A 33- member panel, composed of private citizens, prevention advocates, and government agencies, was appointed by the Governor to coordinate this effort.

Expansion of Services for Children

During the 2000-2001 biennium, the DMHA moved toward the goal of expanding services to children with serious emotional disturbance (SED) by actively promoting the concept of wraparound services. This initiative has encouraged local service providers to coordinate their efforts in planning and service delivery and to pool resources to the greatest extent possible. Community agencies such as schools, juvenile justice, community mental health centers, county offices of the Division of Family and Children (DFC), and other local service providers will be involved to assure success.

Beginning in Federal Fiscal Year (FFY) 2000, two Indiana programs received federal grants to facilitate the expansion of wraparound services for children. The recipients were the Dawn Project, serving Marion County, which began operation in 1995 with funding from the Robert Wood Johnson Foundation, and Circle Around Families (CAF), serving the communities of East Chicago, Gary, and Hammond.

The DMHA, in collaboration with the Division of Family and Children (DFC), awarded contracts to four additional local entities to develop and implement community-based systems of care. The project funds were used to hire project coordinators and to obtain technical assistance in the development of systems of care.

The 2001 Indiana General Assembly approved legislation (P.L. 282-2001) which encouraged the DMHA to award 5 new grants to local entities to employ the community focused and wraparound principles used in the successful Dawn Project.

SOF Agreement Type

The Division of Mental Health and Addiction recognized the need to address two issues facing the state psychiatric hospitals. First, DMHA needed to develop appropriate community-based services to accommodate the transition of long-term patients to the community. Second, DMHA wanted to reduce the number of adults with serious mental illness on waiting lists to enter those same hospitals. Both issues were addressed through an initiative to discharge individuals who had been in the hospital for three or more years. Because most people entering the hospitals since SFY 1999 stay only approximately six to seven months, it was believed that there could be possibly two admissions per year for every long-term bed that became vacant.

The new initiative, designated the SOF Agreement Type, relies on DMHA's method of funding community services through risk adjusted groups, or agreement types. This new agreement type supports placement of eligible individuals in the state psychiatric hospitals who have a community mental health center as their gatekeeper. Eligibility for this agreement type was determined initially by a hospital length of stay of three years or longer, which later changed to two years or longer.

In the 2000-2001 biennium there were three DMHA solicitations to the CMHCs for the SOF Agreement Type. Fifteen community mental health centers contracted to participate, and they were able to move 110 people out of the hospitals and into the community during SFY 2000 and SFY 2001 (see Figure 1.1).

Figure 1.1

	Evansville State Hospital	Logansport State Hospital	Madison State Hospital	Richmond State Hospital	Larue Carter Memorial Hospital	Delta	Total
Contracted, moved in SFYs 2000 & 2001	21	42	8	30	6	3	110
Contracted in SFY 2002	4	17	4	6	2	6	39

Source: Indiana Division of Mental Health and Addiction

New Initiatives at the State Psychiatric Hospitals

In September 1999, Governor O'Bannon created the Council on State-Operated Care Facilities. The Council was charged with the development of a long-range plan to ensure the provision of high quality, cost efficient care in all state psychiatric hospitals. The council relied on input from a variety of key stakeholders to develop specific recommendations to achieve this goal. One recommendation of the Governor's Council on State-Operated Care Facilities being developed by FSSA is the Southeast Regional Service Center. This project is being developed through a series of work groups that will include consumers, families, providers, and advocacy groups, and will include the coordination of regional services, as well as the development of services that do not currently exist. Additionally, it will include a regional center and quality improvement for all services.

A major challenge for the state psychiatric hospital system will be compliance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (Public Law 104-91). Its purpose is to assure portability and continuity of health care, combat fraud and abuse, promote medical savings accounts, improve long term care access and coverage, and simplify the administration of health insurance. HIPAA required the Secretary of the Department of Health and Human Services to enact rules to establish

national standards, including the confidentiality and security of health information. The Family and Social Services Administration (FSSA) is assessing the fiscal impact of these new rules. Each hospital began analyzing changes that would occur locally in order to gain compliance with HIPPA regulations, and a statewide work group is addressing issues as a system.

INDIANA DIVISION OF MENTAL HEALTH AND ADDICTION FUNDING

Biennium Appropriations

Figure 1.2 provides information for State Fiscal Years (SFYs) 1998-2001 Division of Mental Health and Addiction biennial appropriations for community-based and state hospital services and for administration. After subtracting transferred funds, there was a $19.0 million increase in appropriations for community-based services in the SFY 2000-2001 biennium. Appropriations for state psychiatric hospital services increased by $47.2 million.

Figure 1.2

DMHA Biennium Appropriations* SFY 1998-1999 and SFY 2000-2001 Operating Budget (in millions)		
	SFY 1998-1999	SFY 2000-2001
Community-Based Services	$307.1	$337.8
….Community-Based Mental Health	$229.5	$227.9
….Community-Based Addiction	$77.6	$109.9
State Hospital Services	$211.1	$258.3
TOTAL SERVICES	$518.2	$596.1
Administration	$10.5	$6.9
Research & Quality Assurance	$0.4	$4.5
TOTAL DMHA Budget	$529.1	$607.5

**The State of Indiana list of appropriations, for the bienniums shown above, does not include transferred funds in the totals.*
Source: State of Indiana List of Appropriations for the Biennium July 1, 1997 to June 30, 1999 and for the Biennium July 1, 1999 to June 30, 2001

Federal and State Funds

In the SFY 2000-2001 biennium, the Substance Abuse and Mental Health Services Administration (SAMHSA), Substance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) block grant awards accounted for 13.8% of the DMHA budget.

The Substance Abuse Prevention and Treatment (SAPT) block grant is administered by the federal Department of Health and Human Services, SAMHSA, Center for Substance Abuse Treatment (CSAT). Receipt of this block grant has brought with it federally-imposed spending requirements. Among these requirements are that 20% of the award must be spent for alcohol and drug abuse prevention services. Treatment services for pregnant women and women with dependent children must also be funded. In SFY 1996, support of substance abuse services for persons at high risk of contracting the human immunodeficiency virus (HIV) was an added requirement. In SFY 1998, the DMHA was required to spend just under $2 million for substance abuse services for persons with a disability determination of drug addiction or alcoholism who are eligible for Social Security Disability (SSD) or Supplemental Security

Income (SSI) payments. In SFY 1999, the DMHA spent $6.6 million for prevention services, $5.5 million for services for pregnant women and women with dependent children, and $1.5 million for early HIV intervention services. As in the past, the state must maintain the required percentage of expenditures for targeted populations as a condition of receiving the block grant.

The Center for Mental Health Services (CMHS) block grant is also administered by SAMHSA. To receive these funds, the DMHA develops an annual state plan and an implementation report for the preceding year addressing five criteria related to a comprehensive, community-based system of care for adults with serious mental illness (SMI) and for children with serious emotional disturbance (SED). Activities related to this block grant are overseen by the Mental Health Planning Council, comprised of members of the DMHA's advisory committees for Adults with SMI, Children with SED, Critical Populations, and Older Adults and Persons with Disabilities Bureaus. In SFY 2000-2001, the CMHS block grant accounted for 2.6% of DMHA funds, an increase of $2.6 million from the prior biennium.

State funds include a portion of taxes ("dedicated funds") collected on the sale of alcoholic beverages and cigarettes, funds collected by the clerk of courts from various court fees, and ten cents of each riverboat casino admission fee. In the SFY 2000-2001 biennium, state general and dedicated funds represented 84.7% of the total DMHA budget, compared with 84.4% of the total SFY 1998-1999 biennium budget.

DMHA Biennium Budgets

Figure 1.3, which includes transferred funds, shows the DMHA Biennium Budget for two biennial periods.

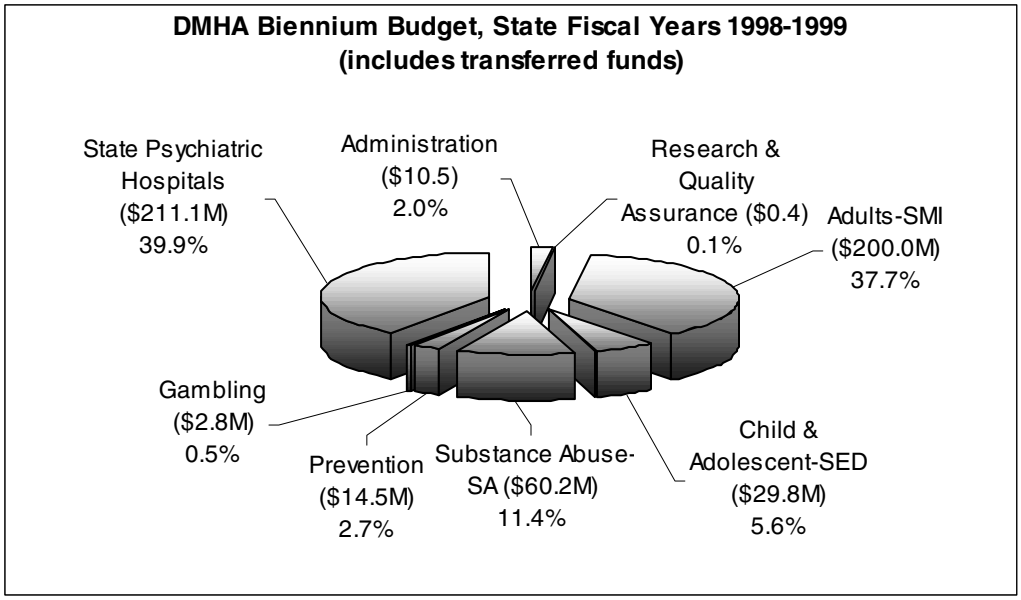
The distribution of funds into the SMI and SED categories decreased over the biennial period, from $229.8 million to $227.9 million. The substance abuse category increased by $21.4 million.

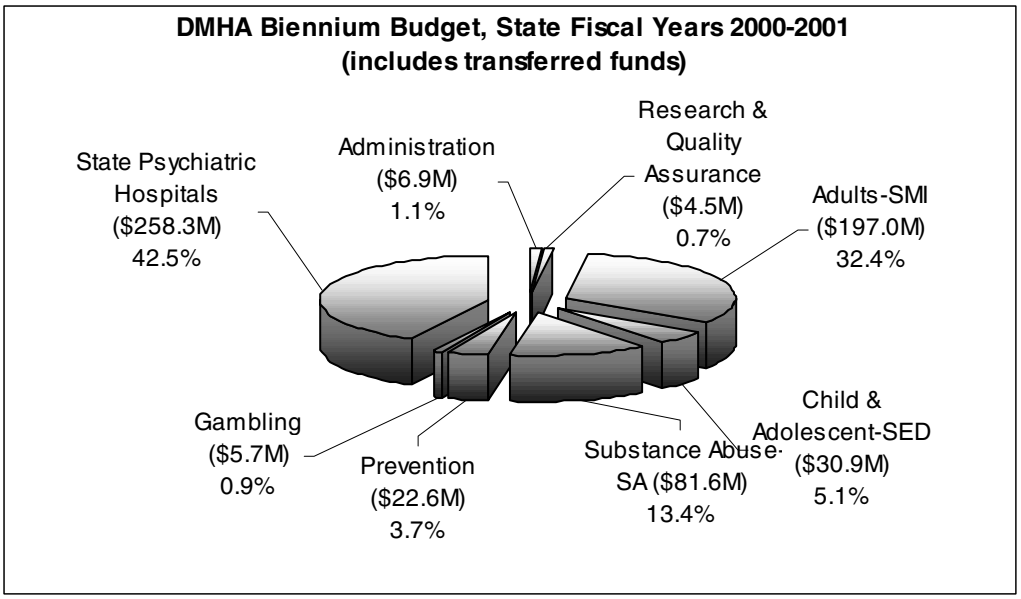
DMHA-supported prevention of alcohol, tobacco, other drug abuse, and problem gambling efforts are 90% federally funded. From the 1998-1999 biennium to the 2000-2001 biennium, prevention funding increased by $8.1 million.

The 1993 Indiana General Assembly passed a law requiring that ten cents of each admission tax to Indiana riverboats be paid to DMHA and placed in the Gambler's Assistance Fund. The 1995 General Assembly amended the law for these monies to be used "…for the prevention and treatment of addictions to drugs, alcohol, and compulsive gambling, including the creation and maintenance of a toll-free telephone line to provide the public with information about these addictions." DMHA is required to allocate at least 25% of these funds to the prevention and treatment of compulsive gambling. Across the two bienniums, the gambling distribution increased by $2.9 million.

Figure 1.3 also shows that the distribution of funds into the state psychiatric hospital category increased over the two biennial periods by $47.2 million. The increase in hospital expenditures during this time are primarily due to the pay differential given to nurses and large increases in pharmacy costs associated with the cost of medication.

Figure 1.3

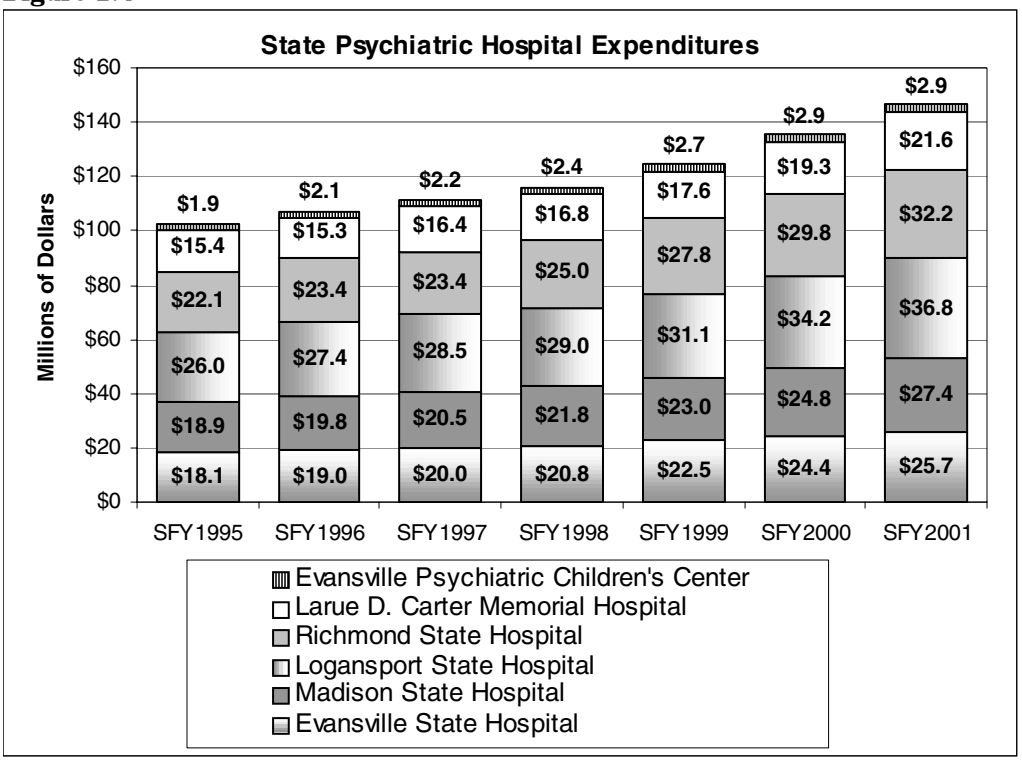




Source: State of Indiana List of Appropriations for the Biennium July 1, 1997 to June 30, 1999 and for the Biennium July 1, 1999 to June 30, 2001

State Psychiatric Hospitals: Figure 1.4 shows expenditures for the state psychiatric hospitals from SFY 1995 to SFY 2001. As noted previously, increases in hospital expenditures are due to pay differentials and large increases in pharmacy costs.

Figure 1.4

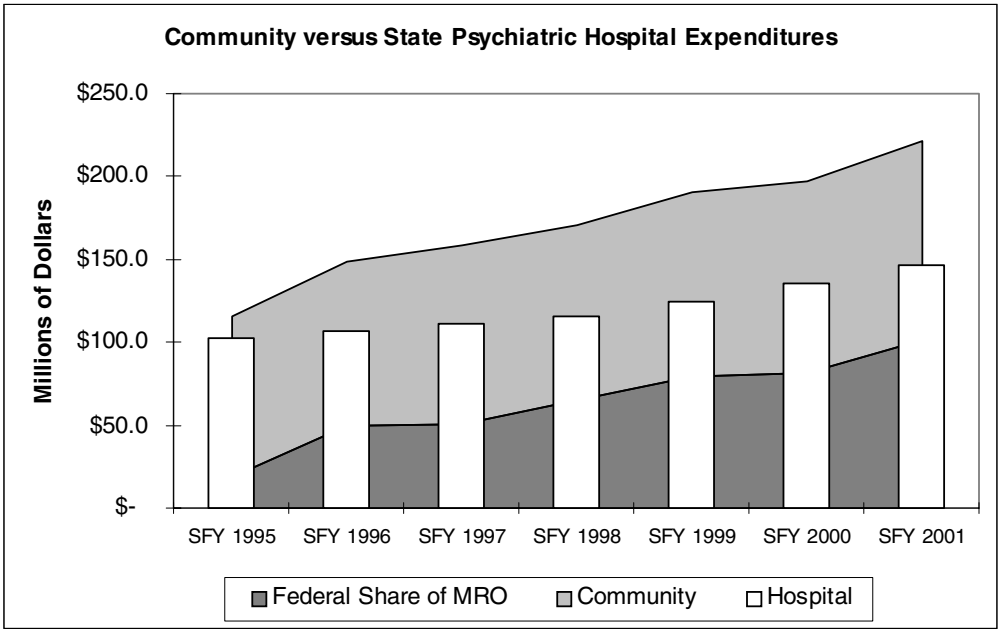


Source: FSSA Office of Budget and Finance

Community versus Institutional Expenditures

Figure 1.5 compares community mental health services expenditures to state psychiatric hospital expenditures over nine state fiscal years.

Figure 1.5



Source: DMHA MERR databases, Community Services Data System, and FSSA Office of Budget and Finance

Medicaid Rehabilitation Option (MRO)

Medicaid is a health care program for low-income and disabled individuals that is jointly financed by the state and federal governments. Each state administers its own program within broad federal guidelines. In Indiana, the DMHA, under an interagency agreement with the Office of Medicaid Policy and Planning (OMPP), is responsible for the administration of certain community-based services for persons with mental illness and/or chronic addiction under the Medicaid Rehabilitation Option (MRO).

The MRO is a funding mechanism designed to augment traditional medically oriented Medicaid clinic services with rehabilitation oriented services with DMHA funding through the OMPP. In Indiana, persons eligible for MRO services are Medicaid enrolled and meet the diagnostic categories under the Hoosier Assurance Plan (HAP). Those categories are: adults with serious mental illness (SMI), children with serious emotional disturbance (SED), and persons with substance abuse (SA).

DMHA contracts with community mental health centers (CMHCs) throughout Indiana to provide MRO services to those who qualify for them. Through the Medicaid federal/state partnership, the federal government pays approximately 62% of total MRO expenditures. The remaining 38%, also called the state match, is paid by the DMHA and the CMHCs.

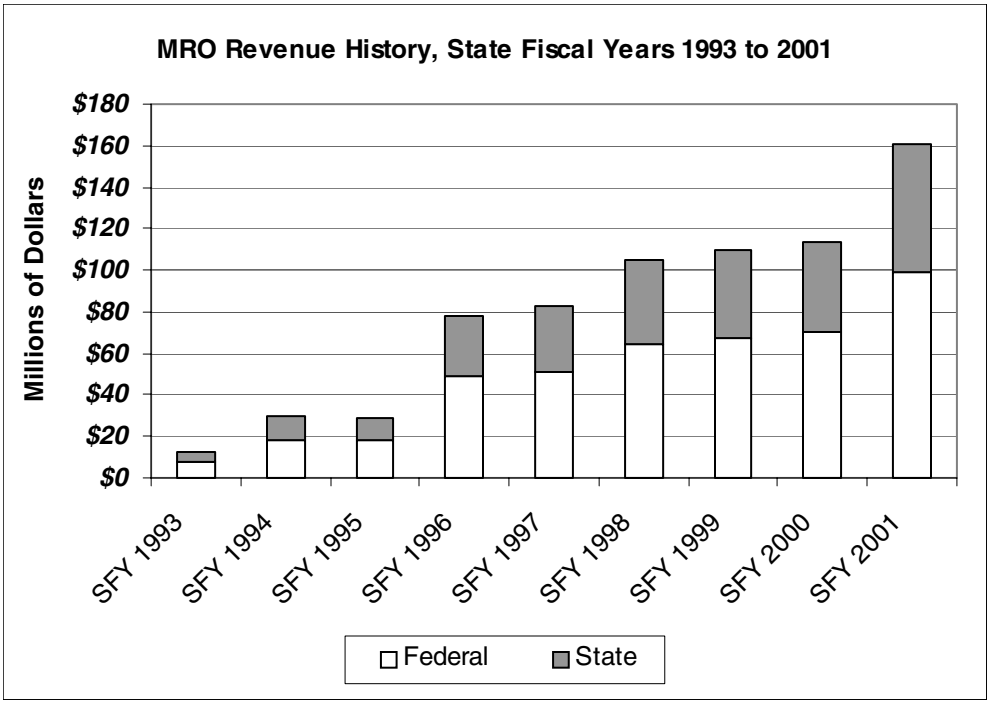
During the first year of MRO operation the program's total expenditures were approximately $13 million. Since that time total MRO expenditures have continued to grow. In SFY 2001, total MRO expenditures exceeded $160 million. Approximately 41% of the total SFY 2001 MRO expenditures were spent on targeted case management services. The number of consumers receiving MRO services also continues to increase. In SFY 1993, almost 9,000 individuals received MRO services. By SFY 2000 that number had surpassed 43,000 individuals.

Indiana has designed a conservative MRO program, as compared to other states, in that Indiana has limited services. As a result, the Indiana MRO program is continually being enhanced and refined. The DMHA Best Practices Committee develops guidelines for services available through MRO to ensure that participating providers are compliant with Medicaid regulations and other program requirements. The committee is composed of representatives from CMHCs who are clinicians or otherwise involved in developing or managing programs, representatives from DMHA, and a representative from the Indiana Council of Community Mental Health Centers (ICCMHC).

In addition to the Best Practices Committee, there is a MRO Revenue and Billing Committee that meets quarterly to discuss billing policies and procedures and to ensure that billing practices are compliant with Medicaid regulations. The Revenue and Billing Committee is comprised of representatives from CMHCs, DMHA, ICCMHC, Electronic Data Systems, Inc. (EDS), and Health Care Excel (HCE).

Between SFYs 1993 and 2001, Indiana's CMHCs accessed additional federal funds through the MRO to pay for outpatient care, partial hospitalization, and case management services for persons with SMI, SED, or a substance abuse (SA) disorder. The CMHCs use other, non-DMHA state dollars as match to enhance their MRO dollars. Indiana's MRO funds have the potential to increase as long as state matching funds are available and no federal "cap" is placed on the amount of match that can be claimed. In SFY 2001, MRO federal matching funds were $99 million. See Figure 1.6.

Figure 1.6



Sources: Office of Transitional Services, DMHA; OMPP Dataprobe